U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 09 May 2005

Case No.: 2004-BLA-06739

In the Matter of

JOSEPH R. KUFROVICH
Claimant

v.

BETHENERGY MINES INC.
Employer

and

BETHLEHEM STEEL CORP.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Helen M. Koschoff, Esquire
Claimant

John J. Bagnato, Esquire
Employer

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

[1] The regulations cited are the amended regulations, effective January 19, 2001, found at 20 C.F.R. § 718, et seq. (2001).

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On August 30, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. DX 26.[2] Subsequently, the case was assigned to me. A hearing was held on January 28, 2005, in Wilkes-Barre, Pennsylvania. Employer submitted a brief on March 14, 2005. Claimant did not submit a brief. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:

(1) the length of Claimant's coal mine employment history;

(2) whether Claimant has pneumoconiosis;

(3) whether Claimant's pneumoconiosis arose out of coal mine employment;

(4) whether Claimant is totally disabled; and

(5) whether Claimant's total disability is due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural History

Claimant filed this claim for benefits on July 21, 2003. DX 2. On June 7, 2004, the District Director determined that Claimant had failed to establish any of the elements of entitlement, other than having worked in coal mine employment, and denied the claim. DX 22. Claimant requested a formal hearing on June 16, 2004. DX 23.

B. Factual History

Claimant's first coal mine employment was with Carbonite Filter from 1970 to 1975 where he worked as a laborer. Claimant described Carbonite Filter as a coal preparation plant that sized and cleaned coal, and his duties consisted of packaging, sweeping the floor, repairing equipment, loading trucks, and loading the hoppers. Tr. 27-28. Claimant stated that he next worked in coal mine employment at Greenwood Stripping in 1975, where he worked as a repairman/mechanic. Tr. 28. Claimant then worked for BethEnergy Mines, Joseph Pakaski, and

[2] The following abbreviations are used herein: "CX," refers to Claimant's exhibits; "DX," refers to Director's exhibits; "EX," refers to Employer's exhibits; and "Tr.," refers to the transcript of the January 28, 2005 hearing.

Lehigh Coal and Navigation Company. His primary job was as a mechanic on the rotary blast drills, but he also repaired bulldozers, trucks, and loaders. Claimant testified that the heaviest weight he was required to carry was 220 to 240 pounds. He also stated that he was required to climb to reach certain areas, including a boom that was approximately 120 feet high. Tr. 28-30. Claimant stopped working in 1989 due to complications from surgery for Hodgkin's disease. Tr. 36.

Claimant started to experience breathing problems approximately two years ago. Tr. 30. He stated that he can only ascend two or three stairs or walk about 10 yards before experiencing shortness of breath. Tr. 31. Claimant also experiences bouts of coughing that occur mostly in the morning and that produce yellowish-brown sputum. Tr. 33. Claimant's medical history also includes high blood pressure and successfully treated Hodgkin's disease that was diagnosed in 1987. Tr. 32, 34-35.

C. Entitlement

Because this claim was filed after the effective date of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

D. Length of Coal Mine Employment

Employer concedes that Claimant has a coal mine employment history of at least 13 years. Tr. 23. Director credits Claimant with 14 years of coal mine employment. DX 22. Claimant credibly testified that his coal mine employment began in 1970 and ended in 1989. Tr. 27-29, 36. Claimant's Social Security earnings records and coal mine employment forms corroborate Claimant's testimony. DX 3, 6. Social Security earnings records and coal mine employment forms submitted with the claim may constitute substantial evidence. *Schmidt v. Amax Coal Co.*, 7 B.L.R. 1-489 (1984). Additionally, the calculation of coal mine employment history may also be based on Claimant's testimony where it is uncontradicted and credible. *Gilliam v. G & O Coal Co.*, 7 B.L.R. 1-59 (1984). I find that Claimant's testimony regarding the dates of his coal mine employment are credible and well documented and consistent with the record. Therefore, I find that Claimant has established a coal mine employment history of 19 ¼ years.

E. Element of Entitlement

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

(1) X-ray evidence. § 718.202(a)(1).

(2) Biopsy or autopsy evidence. § 718.202(a)(2).

(3) Regulatory presumptions. § 718.202(a)(3).

a) § 718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

(4) Physician's opinions based upon objective medical evidence § 718.202(a)(4).

The Third Circuit Court of Appeals has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 25 (3d Cir. 1997). This case arises in the jurisdiction of the Third Circuit Court of Appeals because Claimant's coal mine employment took place in Pennsylvania.

X-ray evidence, § 718.202(a)(1)

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102. The record contains the following current X-ray interpretations summarized in the following table:[3]

[3] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASS
09/11/03	09/11/03	DX 9	Dr. Zacher	BCR	0/1
09/11/03	02/20/04	CX 1	Dr. Ahmed	BCR, B-reader	1/1 (Rebuttal)
01/30/04	07/19/14	CX 11	Dr. Miller	BCR, B-reader	1/2
01/30/04	02/03/04	EX 1	Dr. Ciotola	BCR, B-reader	0/0 (Rebuttal)
01/30/04	05/20/04	EX 3	Dr. Wolfe	BCR, B-reader	0/1
02/18/04	03/08/04	CX 10	Dr. Smith	BCR, B-reader	1/0
05/18/04	07/27/04	EX 4	Dr. Wolfe	BCR, B-reader	0/1
05/18/04	10/08/04	CX 8	Dr. Cappiello	BCR, B-reader	1/1 (Rebuttal)
05/18/04	11/26/04	EX 6	Dr. Wolfe	BCR, B-reader	0/1 (Rehabilitative)

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6 B.L.R. 1-535, 537 (1983); *Sharpless v. Califano*, 585 F.2d 664, 666-7 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979).

The September 11, 2003 chest X-ray was interpreted as negative by Dr. Zacker, a Board-certified radiologist. The X-ray was also interpreted as positive by Dr. Ahmed, a Board-certified radiologist and a B-reader. As Dr. Ahmed's qualifications are superior to those of Dr. Zacker, I find that Dr. Ahmed's interpretation is entitled to greater weight. Therefore, I find the September 11, 2003 chest X-ray is positive for the presence of pneumoconiosis.

The January 20, 2004 chest X-ray was interpreted as negative by Drs. Ciotola and Wolfe, both Board-certified radiologists and B-readers. The X-ray was also interpreted as negative by Dr. Miller, a Board-certified radiologist and B-reader. As more B-readers interpreted the X-ray as being negative, I find that the January 20, 2004 chest X-ray is negative for the presence of pneumoconiosis.

The February 18, 2004 chest X-ray was interpreted as positive by Dr. Smith, a Board-certified radiologist and B-reader, and is essentially unrebutted. Consequently, I find that the February 18, 2004 chest X-ray is positive for the presence of pneumoconiosis.

The May 18, 2004 chest X-ray was interpreted as negative by Dr. Wolfe, a Board-certified radiologist and B-reader. The X-ray was also interpreted as positive by Dr. Cappiello, a Board-certified radiologist and B-reader. Employer had Dr. Wolfe interpret the same X-ray a second time and the physician again interpreted the X-ray as negative. As both physicians are equally qualified, I find that their interpretations are in equipoise. Accordingly, I find that the May 18, 2004 chest X-ray is neither positive nor negative for the presence of pneumoconiosis.

Considering all of the X-ray evidence together, I find that the weight of the X-ray evidence supports a finding of the presence of pneumoconiosis.[4]

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or

[4] Claimant's medical records include a chest X-ray taken on September 17, 2002, at Miner's Memorial Medical Center. Dr. Kevin Stempel found "minimal bilateral pleural thickening laterally (right side greater than left)." EX 9. However, Dr. Stempel did not classify Claimant's chest X-ray in any ILO category, nor did he interpret the chest X-ray film as positive for the presence of pneumoconiosis as required under § 718.102(b). Consequently, I find that the September 17, 2002 chest X-ray is not in compliance with the regulations and can not be considered evidence of the presence, or absence, of pneumoconiosis.

> suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201(a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The following medical opinions are of record:

Dr. Stephen M. Kruk (CX 9)

Dr. Stephen M. Kruk (Board-certified in internal medicine) examined Claimant on April 14, 2004, and issued a report on the date. The physician credited Claimant with 13 to 18 years of coal mine employment and considered a smoking history of 10 years, noting that Claimant quit smoking approximately 14 years ago. Dr. Kruk documented Claimant's reported symptoms of progressive shortness of breath and chronic cough. Claimant's history of Hodgkin disease and hypertension were noted. Dr. Kruk's examination revealed generally clear lungs, and no edema in the lower extremities. The doctor observed that a spirometry performed that day showed "changes consistent with obstructive and restrictive defects primarily restrictive". The doctor subjected Claimant to a treadmill test using the Naughton protocol, which was terminated due to Claimant's shortness of breath. A cardiogram showed nonspecific changes. Dr. Kruk observed that a chest X-ray dated February 18, 2004 was read by a B reader who interpreted the presence of pneumoconiosis in all lung zones. Dr. Kruk concluded that the "spirometry along with his stress test and chest x-ray reports along with clinical work history are all consistent with coal worker's pneumoconiosis".

Dr. Raymond J. Kraynak (CX 8)

Dr. Raymond J. Kraynak issued a report dated May 20, 2004, in which he opined that Claimant suffers from pneumoconiosis. Dr. Kraynak recorded Claimant's symptoms of shortness of breath, productive cough and exertional dyspnea, as well as his productive cough that is more prevalent in the morning. Dr. Kraynak also noted Claimant's history of Hodgkin's lymphoma and hypertension, as well as his hypothyroidism. Claimant's smoking history of approximately fifteen years was reported. Dr. Kraynak reviewed a pulmonary function study of February 18, 2004, and a chest X-ray of the same date that he noted was interpreted by Dr. Smith

as positive for pneumoconiosis. Dr. Kraynak's examination of the Claimant reported that he had mild increase in AP diameters in the chest and lungs, with scattered wheezes in all lung fields, but no rales or rhonchi. No deformities or edema of the extremities was observed. Dr. Kraynak noted that Claimant's lips were slightly cyanotic. His neurological examination was normal. Based upon Claimant's work history, symptoms, diagnostic studies and his examination, Dr. Kraynak concluded that the Claimant is totally and permanently disabled, secondary to pneumoconiosis.

Dr. Kraynak testified on December 17, 2004 that the Claimant has been under his care since February 18, 2004, and stated that he sees Claimant every two to three months. CX 8 at 8. Dr. Kraynak treats Claimant for his symptoms of shortness of breath, productive cough, and difficulty walking short distances. Id. at 9. Claimant was prescribed a Combivent inhaler, in addition to blood pressure medication. Id. Dr. Kraynak reiterated Claimant's medical and personal history and testified that Claimant's condition is stable. Id. at 10. His smoking history was noted. Id. Dr. Kraynak testified about the results of his examination, essentially repeating the findings and conclusions documented in his report. Id. at 11-13. Dr. Kraynak concluded that the results of the pulmonary function test that he administered to Claimant on October 26, 2004 were valid and conforming to the regulations. Id. Dr. Kraynak also referred Claimant to Dr. Kruk to rule out any cardiac impairment, and he understood that Dr. Kruk had done so. Id. at 14.

Dr. Kraynak concluded that the Claimant had disabling pneumoconiosis, and referred to a chest X-ray dated January 30, 2004 that was interpreted by Drs. Ciotola, Wolfe, Ahmed, Miller and Cappiello, and a chest X-ray dated May 18, 2004. The physician also relied on pulmonary function tests dated September 11, 2003, February 18, 2004, March 26, 2004, April 14, 2004, May 18, 2004, October 26, 2004, November 8, 2004, and an arterial blood gas study dated May 18, 2004. Dr. Kraynak reviewed the report of Dr. Santarelli dated November 13, 2003, report of Dr. Kruk dated April 14, 2004, report of Dr. Dittman dated April 20, 2004, and Dr. Hertz's report dated May 18, 2004. The physician also opined that Claimant's smoking history would not give rise to his pulmonary impairment as the history was not significant enough. Dr. Kraynak rejected the contention of at least one physician that some of the Claimant's complaints of shortness of breath could be due to his weight, which was recorded at over 300 pounds. CX 8.

Dr. Kraynak's treating records for the Claimant are also in evidence, but they are largely indecipherable and of little probative value.

Dr. Jonathan Hertz (EX 2; EX 11)

Dr. Jonathan Hertz (certified in pulmonary and internal medicine and a past B reader) examined Claimant at the behest of Employer on May 18, 2004, and issued a report documenting his findings, in which the doctor credited Claimant with a coal mine employment history of between 13 and 17 years and considered a smoking history of one-pack of cigarettes a day for ten to twelve years. Dr. Hertz observed Claimant's reported symptoms of shortness of breath after walking brief distances or climbing stairs, and his morning cough and phlegm production. Claimant's use of an inhaler and other medications was noted, and the Claimant reported treatment for pneumonia on three occasions during the past twelve to eighteen months. Records

of those hospitalizations were not available to Dr. Hertz.[5] The physician's physical examination of Claimant revealed no abnormalities of the throat, ears, eyes, or thyroid, although the doctor characterized Claimant as obese at 302 pounds. His chest exam "show[ed] good breath sounds through both lung fields, with no crackles, no wheezes, and no rhonchi. Breath sounds are symmetric. Chest expansion is symmetric." Claimant's cardiac exam showed a grade 2/6 holosystolic murmur, but was otherwise normal. EKG performed that day was normal. Dr. Hertz performed a chest X-ray that showed normal heart size and clear lungs, and that showed no evidence of pneumoconiosis. The doctor gave the exam "an A-reading of 0/0". The doctor was unable to validate a pulmonary function test that Claimant underwent that day because it showed unreliable effort by Claimant. Arterial blood gas study performed that day produced normal results.

Dr. Kruk also reported the results of his review of medical records, including chest X-rays dated September 11, 2003, and January 20, 2004 and medical reports of Dr. Fino regarding the September 11, 2003 pulmonary function test; Dr. Dittman's report dated April 20, 2004; and Dr. Santarelli's report dated November 13, 2003. The physician found that Claimant did not have pneumoconiosis and opined that Claimant's pulmonary complaints could have a cardiac basis. In coming to that opinion, Dr. Hertz noted that Claimant had a grade 2/6 holosystolic heart murmur and subjective complaints regarding episodes of awakening with tightness in his chest that took over an hour to dissipate. The physician admitted that such symptoms could also have a pulmonary basis, but stated that he would expect such episodes to also occur during daytime hours and be accompanied by coughing and phlegm production if pulmonary in nature. Dr. Hertz also stated that Claimant's heart murmur suggested possible valvular heart disease and a leaky heart valve.

On November 23, 2004, Dr. Hertz testified about his examination of the Claimant and review of the medical evidence. Dr. Hertz reiterated his opinion regarding the relationship between the Claimant's symptoms and cardiac condition. EX 11 at 21-24. In addition, the doctor emphasized the effect of Claimant's obesity upon his medical condition. Id. Dr. Hertz discounted the Claimant's past smoking history as a significant factor relative to his current symptoms. Id. at 26. Although Dr. Hertz admitted that Claimant's symptoms were consistent with pneumoconiosis, he concluded that it would be unusual for an individual to develop the symptoms so many years after exposure to coal dust had ended. Id. at 28-30. Dr. Hertz described five factors that he and other pulmonary doctors would generally consider to diagnose pneumoconiosis: history, physical examination, chest X-ray, pulmonary function tests and arterial blood gas studies. EX 11 at 41-44.

Dr. Thomas Dittman (DX 10; EX 10)

Dr. Thomas Dittman (certified in internal medicine) examined Claimant at the behest of the Employer on January 20, 2004, and issued a report dated April 20, 2004 in which he credited Claimant with 13 years of coal mine employment and considered a past smoking history of one

[5] Records referring to Claimant's treatment at the hospital for pneumonia are of record at EX 8 and EX 9. At the hearing, I admitted this evidence over Claimant's objection, but limited my consideration of the records to those addressing treatment for pulmonary conditions, or other conditions that medical experts reasonably can relate to Claimant's symptoms. See, TR. at 13-15.

and one-half packs of cigarettes a day for eighteen years. Dr. Dittman noted Claimant's symptoms of intermittent shortness of breath, and dyspnea, as well as tightness in his anterior chest. Claimant's morning cough and sputum production were also documented. Dr. Dittman observed that Claimant had never been hospitalized for respiratory reasons. Claimant's Hodgkin's disease, hypertension, and past pneumonia were noted. Dr. Dittman's examination of Claimant revealed no abnormalities of the chest or lungs, and no wheezes, rhonchi, rales or rub were noted. A grade 2 systolic murmur was observed, but his cardiac exam was otherwise normal. An electrocardiogram produced no acute abnormalities. The Claimant refused an arterial blood gas study. The doctor referred to a chest X ray that was interpreted by Dr. Ciotola as negative for pneumoconiosis. A pulmonary function test was performed on March 26, 2004, and showed inconsistent and less than maximum effort on Claimant's part. Dr. Dittman found the test results unreliable. The physician also reviewed arterial blood gas studies dated September 11, 2003 and May 18, 2004, treatment records and reports by Drs. Santarelli and Hertz. Dr. Dittman concluded that Claimant did not have pneumoconiosis, but noted that he had symptoms typical of angina pectoris that could indicate coronary artery disease.

Dr. Dittman testified about the results of his examination and his review of medical evidence, and rejected the conclusion that Claimant's symptoms could be attributed to pneumoconiosis. Dr. Dittman referred to the variability of his symptoms, which contrasted with the consistent nature of symptoms that would be related to dust exposure. He also pointed to the long period of time between the exposure and the onset of symptoms as a reason to discount pneumoconiosis as the cause. EX 10 at 13-14; 22-23. Dr. Dittman agreed with Dr. Hertz that Claimant's obesity could contribute as a cause of Claimant's shortness of breath. Id. at 20. Dr. Dittman reiterated his opinion that Claimant does not have pneumoconiosis or pulmonary dysfunction. Id. at 21. Dr. Dittman testified that in the absence of valid pulmonary function findings, he could not conclude that Claimant has a disability. EX 11 at 31. With respect to his conclusions that Claimant's symptoms could be related to a cardiac impairment, Dr. Dittman observed that he is taking medications that are used for the treatment of coronary artery disease, as well as hypertension. Id. at 32. Dr. Dittman also conjectured that Claimant's symptoms could be related to sleep apnea, but he admitted that that condition had not been diagnosed by any other medical expert. Id. at 33.

Dr. Rocco J. Santarelli

Dr. Rocco J. Santarelli examined Claimant at the behest of the Department of Labor on November 13, 2003, and issued a report on that date. The physician credited Claimant with 19 years of coal mine employment and considered a smoking history of nine to 10 years at one-pack of cigarettes a day. Dr. Santarelli relied on his physical examination of Claimant, a chest X-ray, pulmonary function test, arterial blood gas study, and electrocardiogram all dated September 11, 2003. The physician diagnosed Claimant with restrictive lung disease and morbid obesity. Dr. Santarelli stated that the etiology of Claimant's conditions were unknown. DX 9. I infer from this that Dr. Santarelli is of the opinion that Claimant does not have pneumoconiosis.

Treatment Records (EX 8; EX 9)

Records of Claimant's treatment by Dr. Krause reflect that he was prescribed Norvasc, in addition to other medications. On November 19, 2003, the doctor noted that Claimant had been treated at the emergency room for pneumonia. The emergency room report documents this treatment on October 24, 2003, and returned for follow up on October 27, 2003. Upon examination, his lungs were consistently clear. Dr. Krause observed no heart murmur. A pulmonary function test performed on September 11, 2003 was observed by Dr. Joseph Mariglio to demonstrate poor effort.

Discussion of Medical Opinion Evidence

I credit Dr. Kruk's conclusions, which are consistent with the objective evidence upon which he based them, including an X-ray that I have determined to show the presence of pneumoconiosis, and a pulmonary function study whose validity was not effectively challenged, as discussed herein. Dr. Kruk concluded that Claimant has pneumoconiosis based upon the "spirometry along with his stress test and chest x-ray reports along with clinical work history are all consistent with coal worker's pneumoconiosis. . ." CX 9.

In reaching his opinion that Claimant has pneumoconiosis, Dr. Kraynak relied upon a number of chest X-ray interpretations that I have found in excess of the evidentiary limitations established by regulation. Medical reports may only be based on medical evidence that is admissible under the limitations set for in §§ 725.414(a)(2)(i) and 725.457(d). The physician relied on inadmissible interpretations of the September 11, 2003 chest X-ray made by Drs. Ahmed, Cappiello, and Miller, and inadmissible interpretations of the January 30, 2004 chest X-ray made by Drs. Ahmed and Cappiello. Insofar as his opinion is consistent with the objective evidence, I accord some weight to Dr. Kraynak's conclusions. However, I find that his opinion is compromised by his reliance upon evidence that I may not consider in this adjudication. Therefore, I find that Dr. Kraynak's opinion regarding the presence of pneumoconiosis is entitled to little weight. Although Claimant has characterized Dr. Kraynak as his treating physician, and in fact, the record reflects that the doctor has seen Claimant at his office, I decline to accord Dr. Kraynak the status of treating physician for purposes of according his opinion controlling weight pursuant to § 718.104(d). Dr. Kraynak first saw Claimant on February 18, 2004, in association with the instant claim, and has only seen Claimant on three other occasions before testifying about the instant matter. In addition, the record reflects that Dr. Krause has treated Claimant for a number of conditions on a regular basis, though his records do not indicate that he diagnosed Claimant with pneumoconiosis. EX 9. Therefore, I find the record does not demonstrate a doctor-patient relationship that would entitle Dr. Kraynak's opinions about the Claimant's condition to controlling weight.

I find that the opinions of Drs. Hertz, Dittman and Santarelli are well-reasoned and well-documented. A documented opinion is one that sets forth the clinical findings, observations, facts and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). An opinion is reasoned when the underlying data and documentation are adequate to support the physician's conclusions. *Fields*, supra. All three physicians examined the Claimant, conducted objective

medical tests, and considered the other medical evidence of record in reaching their conclusions that Claimant does not have pneumoconiosis. In addition, the physicians recognized the lack of effort expended by Claimant on the September 11, 2003, March 26, 2004 and May 18, 2004 pulmonary function tests and accorded that factor appropriate weight in determining Claimant did not have pneumoconiosis. I place less weight on Dr. Santarelli's opinion, as he observed the inadequate effort but did not conclusively address the issue. However, I accord significant weight to the opinions of Drs. Hertz and Dittman, who both relied upon the evidence of record to conclude that Claimant did not support a finding that Claimant has pneumoconiosis. I note that neither doctor was afforded the opportunity to address all of the X-ray evidence. Although the cumulative chest X-ray is positive for the presence of pneumoconiosis, many well-qualified physicians interpreted the X-rays to be negative. In addition, the other objective medical evidence and medical opinion evidence does not support that finding. Consequently, I find that the weight of the medical opinion evidence does not establish that Claimant has pneumoconiosis.

In consideration of all of the evidence together, like and unlike, pursuant to § 718.202(a), I find that it does not establish that he has pneumoconiosis. Therefore, I find that Claimant has not established the presence of pneumoconiosis, and accordingly, Claimant has failed to establish this element of entitlement.

2. Pneumoconiosis Arising Out of Coal Mine Employment

A miner who is suffering or suffered from pneumoconiosis and was employed for ten years or more in one or more coal mines is entitled to a rebuttable presumption that the pneumoconiosis arose out of such employment § 718.203(b). As previously stated, the parties admitted to at least ten years of coal mine employment, and I have credited him with 19 ¼ years of coal mine employment. However, because Claimant has not established that he has pneumoconiosis, he is not entitled to this presumption, and cannot meet his burden with respect to this element of entitlement.

3. Total Disability

Claimant must establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner
>
> (i) From performing his or her usual coal mine work; and
> (ii) From engaging in gainful employment . . . in a mine or mines . . .

§ 718.204(b)(1).

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability

under the Act. § 718.204(a); see also, Beatty v. Danri Corp., 16 B.L.R. 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993 (3d Cir. 1995).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. § 718.204(b)(2)(i-iv). Producing evidence under one of these four ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of pulmonary function study results are dependent on Claimant's height, which was noted most frequently as 73 inches. I used that height in evaluating the studies. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983).

The current record contains the pulmonary function studies summarized below.

DATE	EX. NO.	PHYSICIAN	AGE	FEV_1	FVC	MVV	FEV_1/FVC	EFFORT	QUALIFIES
09/11/03	DX 9	Dr. Mariglio	50	1.47 1.75*	1.89 2.22*	28.00 42.00*	78% 79%8	Poor Poor*	Yes Yes*
02/18/04	CX 3	Dr. Kraynak	51	2.27	2.92	75.68	77%	Good	Yes
03/26/04	EX 10(3)	Dr. Dittman	51	1.26 1.51*	1.97 2.21*	62.61 --	64% 68%	Inconsistent	Yes Yes*
04/14/04	CX 4	Dr. Kruk	51	2.06	2.76	56.13	74%	Good	Yes
05/18/04	EX 2	Dr. Hertz	51	1.32 2.04*	1.79 2.57*	49.00 57.00*	74% 80%*	Poor	Yes Yes*

*post-bronchodilator

September 11, 2003 Pulmonary Function Study

This study produced qualifying values under the regulations. § 718.204(b)(2)(i). However, Dr. Mariglio noted that Claimant's effort was poor. In addition, both Drs. Gregory J. Fino and Sander J. Levinson found the studies to be invalid. Dr. Fino (Board-certified in internal medicine and pulmonary disease) found that there was a "lack of an abrupt onset to exhalation, a hesitancy and inconsistency in the expiratory flows, a premature termination to exhalation. . ., a lack of plateauing in the expiratory curves, a lack of reproducibility in the expiratory curves, and a complete lack of patient effort and cooperation." Dr. Fino also found that the MVV tracings showed "a breathing frequency less than 60 breaths per minute, erratic tidal volumes, and tidal

volumes measuring less than 50-60% of the observed vital capacity." DX 4. Dr. Levinson (Board-certified in internal medicine and pulmonary disease) also opined that the test was not acceptable as there was "exercise variability of the FEV's [and] hesitation in onset of FVC." DX 9. Dr. Raymond J. Kraynak (Board-eligible in family medicine) stated that his review of the tracings showed a variation of less than 100 milliliters and that he did not detect any hesitation with the FVC. Dr. Kraynak went on to state that he did not detect any of the problems found by Dr. Fino and that the tracings showed good effort throughout. CX 8 at 15-17. It is well-established that pulmonary function tests are effort-dependent and no weight may be given to studies where Claimant puts forth poor effort. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984). Further, as pulmonary function tests are effort dependent, it is generally accepted that spuriously low values are possible but spuriously high values are not. *See Andruscavage v. Director, OWCP*, No. 93-3291, slip op. at 9-10 (3d Cir., February 22, 1994) ("medical literature supports ... the conclusion that [pulmonary function studies] which return disparately higher values tend to be more reliable indicators of an individual's respiratory capacity than those with lower values"). I also accord more weight to the opinions of Drs. Fino and Levinson because of their superior qualifications. Therefore, I find that the September 11, 2003 pulmonary function study is invalid.

February 18, 2004 Pulmonary Function Study

This study produced qualifying values under the regulations. § 718.204(b)(2)(i). The study results contained the required flow volume loop tracings and a notation that Claimant's efforts on the tests were acceptable. Additionally, no evidence was submitted challenging the validity of the test results. Therefore, I find that the February 18, 2004 pulmonary function study is valid.

March 26, 2004 Pulmonary Function Study

This study produced qualifying values under the regulations. § 718.204(b)(2)(i). However, Dr. Dittman (Board-certified in internal medicine) noted that Claimant had expended poor effort in performing the test. It is well-established that pulmonary function tests are effort-dependent and no weight may be given to studies where Claimant puts forth poor effort. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984). Further, as pulmonary function tests are effort dependent, it is generally accepted that spuriously low values are possible but spuriously high values are not. *See, Andruscavage v. Director, OWCP*, supra. Therefore, I find that the March 26, 2004 pulmonary function study is invalid.

April 14, 2004 Pulmonary Function Study

This study produced qualifying values under the regulations. § 718.204(b)(2)(i). The study results contained the required flow volume loop tracings and a notation that Claimant's efforts on the tests were acceptable. Additionally, no evidence was submitted challenging the validity of the test results. Therefore, I find that the April 14, 2004 pulmonary function study is valid.

May 18, 2004 Pulmonary Function Study

This study produced qualifying values under the regulations. § 718.204(b)(2)(i). However, Dr. Hertz (Board-certified in internal medicine, pulmonary disease, and critical care medicine) stated that Claimant's effort in performing the test was poor. EX 11 at 19-89, (3). Dr. David S. Prince (Board-certified in internal medicine and pulmonary disease) opined that the study was valid as the "tracings are uniform, consistent, and reproducible." CX 7. It is well-established that pulmonary function tests are effort-dependent and no weight may be given to studies where Claimant puts forth poor effort. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984). In weighing the opinions of the two physicians, who are dually qualified, I find that Dr. Hertz's opinion regarding Claimant's effort is entitled to more weight. The values on this study are similar to the values produced on the contemporaneous September 11, 2003 study that was found to be invalid by three similarly qualified physicians. Further, as pulmonary function tests are effort dependant, it is generally accepted that spuriously low values are possible but spuriously high values are not. *See Andruscavage v. Director, OWCP*, supra. Therefore, I find that the May 18, 2004 pulmonary function study is invalid.[6]

In consideration of the aforestated, I find that the February 18 and April 14, 2004 pulmonary function tests are valid and qualifying under the regulations, while the September 11, 2003, March 26, 2004, and May 18, 2004 pulmonary function tests are invalid. Therefore, I find that the weight of the pulmonary function evidence supports a finding of total disability pursuant to § 718.204(b)(2)(i).

The current record contains the arterial blood gas studies summarized below.

DATE	EX. NO.	PHYSICIAN	PCO2	PO2	QUALIFIES
09/11/04	DX 9	Dr. Mariglio	42.2 44.0*	61.3 66.9*	No No*
05/18/04	EX 11(3)	Dr. Hertz	40 37*	81 81*	No No*

*post-exercise

The blood gas studies did not yield qualifying results. In his December 17, 2004 deposition, Dr. Kraynak stated that he found Claimant's May 18, 2004 arterial blood gas to be inconsistent as the pre-exercise and post-exercise samples were only taken three minutes apart when the report states that Claimant exercised for 10 minutes. CX 8 at 23-24. However, the September 11, 2003 arterial blood gas study also did not yield qualifying results and has not been

[6] Employer offered a report by Dr. Fino dated September 7, 2004, in which the physician opines that the May 18, 2004 pulmonary function study is invalid. However, Dr. Fino's report exceeds the evidentiary limitations of § 725.414(a)(2)(ii) and (3)(ii). To properly rehabilitate a study or test, the party must submit a statement from the physician who administered the test. Here, Employer offered the report of Dr. Fino as rehabilitative evidence when the physician who "administered" the test was Dr. Hertz. Therefore, I will not consider Dr. Fino's September 7, 2004 report finding the May 18, 2004 pulmonary function study invalid.

impugned. Based on the foregoing, the arterial blood gas evidence does not support a finding that Claimant is totally disabled under the provisions of § 718.204(b)(2)(ii).

Evidence of Cor Pulmonale

Under § 718.204(b)((2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no evidence in the record that Claimant has been diagnosed with cor pulmonale with right-sided congestive heart failure.

Medical Opinion Evidence

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv).

Dr. Kruk found Claimant to be totally and permanently disabled. In coming to this conclusion, the physician relied on a his physical examination of Claimant, a chest X-ray dated February 18, 2004, a treadmill test using the Naughton protocol dated April 24, 2004, and a spirometry performed on the date of his examination. Dr. Kruk also noted that Claimant "becomes extremely dyspneic with minimal exertion as noted on today's treadmill test." CX 9. The physician opined that Claimant "is totally and permanently disabled secondary to coal worker's pneumoconiosis." The doctor also wrote that he "suspect[ed] his cigarette smoking played a minor role also, but …consider[ed] the primary cause of his dyspnea with exertion to be that of coal worker's pneumoconiosis." Dr. Kruk concluded that "[t]he prognosis for any improvement in the future is dismal." CX 9.

I am unable to accord substantial weight to Dr. Kruk's opinion, as it is not well documented. Dr. Kruk purports to rely upon the results of a stress test, but the test was terminated after a brief time because of Claimant's subjective symptoms. Dr. Kruk did not discuss the correlation between Claimant's cardiac condition, which is evidenced by his prescription for hypertension medication, and also by changes observed by Dr. Kruk on a cardiogram that he administered. Dr. Kruk did not explain the onset of symptoms that he attributed to pneumoconiosis years after Claimant's last exposure to coal dust. I find this significant, because the doctor admitted that his past history of smoking could play a role in his dyspnea. Other physicians of record attributed Claimant's exertional dyspnea to obesity, a condition that was not addressed by Dr. Kruk.

I am similarly unable to credit Dr. Kraynak's opinion with significant weight. Dr. Kraynak found that Claimant is totally disabled and "unable to lift, carry, climb steps or walk for any period of time. He must be able to sit, stand and lay at his leisure, secondary to his severe respiratory impairment." In coming to this conclusion, the physician relied on his physical examinations of Claimant, his physician's notes, medical records from Coaldale Hospital, a chest X-ray dated September 11, 2003 that was interpreted by Drs. Zacker, Wolfe, Ahmed, Cappiello and Miller, a chest X-ray dated January 30, 2004 that was interpreted by Drs. Ciotola, Wolfe,

Ahmed, Miller and Cappiello, and a chest X-ray dated May 18, 2004. The physician also relied on pulmonary function tests dated September 11, 2003, February 18, 2004, March 26, 2004, April 14, 2004, May 18, 2004, October 26, 2004, November 8, 2004, and an arterial blood gas study dated May 18, 2004. Dr. Kraynak reviewed the report of Dr. Santarelli dated November 13, 2003, report of Dr. Kruk dated April 14, 2004, report of Dr. Dittman dated April 20, 2004, and Dr. Hertz's report dated May 18, 2004. CX 8.

Despite Dr. Kraynak's access to all of the medical evidence of record, I find his opinion not well documented. Dr. Kraynak cannot be faulted for reviewing evidence that exceeded the evidentiary limitations, but nevertheless, his opinion is compromised to the degree that it is colored by that evidence. Medical reports may only be based on medical evidence that is admissible under the limitations set for in §§ 725.414(a)(2)(i) and 725.457(d). The physician relied on inadmissible interpretations of the September 11, 2003 chest X-ray made by Drs. Ahmed, Cappiello, and Miller, inadmissible interpretations of the January 30, 2004 chest X-ray made by Drs. Ahmed and Cappiello, and inadmissible pulmonary function tests dated October 26 and November 8, 2004. Notwithstanding his opinion regarding inadmissible tests, I find Dr. Kraynak's opinion inconsistent with the record because he did not fully address concerns about pulmonary function tests which I have found to be invalid, mostly because of insufficient effort on testing by Claimant. A medical opinion that relies on nonconforming pulmonary function tests may properly be given less weight. *Arnoni v. Director, OWCP*, 6 B.L.R. 1-423 (1983). Dr. Kraynak did not provide a well-reasoned account for why Claimant's subjective symptoms would have occurred at a time remote from his coal dust exposure, nor does the doctor adequately address the effect of Claimant's past smoking habit on his condition. Dr. Kraynak relied upon Claimant's subjective symptoms in part to reach his conclusion, but did not adequately address the other medical opinions of record that attributed those symptoms to a condition other than pneumoconiosis. Therefore, I find that Dr. Kraynak's opinion regarding total disability is entitled to little weight.

Dr. Hertz opined that Claimant would not be able to return to work in the anthracite coal industry. The doctor specifically declined to base that on a finding of pneumoconiosis, however, and further stated that Claimant did not suffer from any pulmonary disability. EX 11 at 45-46. I find these statements sufficient to find that Dr. Hertz is of the opinion that Claimant is not totally disabled as defined under the Act. Dr. Hertz relied on his physical examination of Claimant, a room air oximetry reading, chest X-rays dated September 11, 2003, January 20, 2004 and May 18, 2004, a pulmonary function test, arterial blood gas study and electrocardiogram all dated May 18, 2004. Dr. Hertz also reviewed Dr. Fino's report regarding the September 11, 2003 pulmonary function test, Dr. Dittman's report dated April 20, 2004, and Dr. Santarelli's report dated November 13, 2003. The physician accorded little weight to the pulmonary function studies he reviewed as he noted that Claimant's effort on the tests was poor. Dr. Hertz also opined that Claimant's shortness of breath and dyspnea on exertion could be related to the "worrisome cardiac signs and symptoms" that he had noted, and to his obesity. EX 11. I find that Dr. Hertz's opinion that Claimant is not totally disabled under the Act is reasoned and well-documented.

Dr. Dittman found that Claimant could return to coal mine employment "from a pulmonary standpoint" as there was "no objective evidence of any pulmonary dysfunction." EX

10. Dr. Dittman elaborated that Claimant has some medical conditions that require further investigation before he could conclusively say that he could return to coal mine employment. Id. at 25. In reaching this conclusion, the physician relied on his physical examination of Claimant, a chest X-ray dated January 30, 2004, a pulmonary function test dated March 26, 2004, and arterial blood gases dated September 11, 2003 and May 18, 2004. Dr. Dittman also reviewed Drs. Santarelli and Hertz's reports dated November 13, 2003 and May 18, 2004, respectively. Dr. Dittman also noted that Claimant's effort on the March 26, 2004 pulmonary function test was inconsistent, which "would falsely lower the results and will reduce the reliability of the testing." EX 10. I find that Dr. Dittman's opinion that Claimant is not totally disabled is reasoned and well-documented.

Dr. Santarelli opined that Claimant's impairment was severe, and the record reflects that the doctor relied on his physical examination of Claimant, a chest X-ray, pulmonary function test, arterial blood gas study, and electrocardiogram all dated September 11, 2003. Although the physician found that the pulmonary function test did show a severe reduction in forced volumes, Dr. Santarelli noted that Claimant's effort on the pulmonary function test was poor. DX 9. The doctor concluded that Claimant had a restrictive lung disease and morbid obesity which together contributed to his severe impairment. I accord little weight to Dr. Santarelli's opinion that Claimant has restrictive lung disease because he heavily relied upon a pulmonary function test which I find to be invalid, and which the doctor himself noted reflected poor effort. As I have previously observed, a medical opinion that relies on nonconforming pulmonary function tests may properly be given less weight. *Arnoni v. Director, OWCP*, supra. Therefore, I find that Dr. Santarelli's opinion regarding the severity of Claimant's impairment is entitled to little weight.

In consideration of the above, I find that the physicians' opinion evidence does not support a finding that Claimant is totally disabled, pursuant to § 718.204(b)(2)(iv).

As I have concluded, the pulmonary function evidence supports a finding of total disability. However, neither the arterial blood gas study evidence nor the physician opinion evidence supports a finding of total disability. I also find that the merit of the pulmonary function study evidence is compromised because the Claimant was shown to have expended inadequate effort in performing the test on more than one occasion. Considering all of the evidence together, I find that Claimant has failed to establish total disability under the provisions of § 718.204(b)(2)(i-iv).

4. Total Disability Due to Pneumoconiosis

As Claimant has failed to establish the presence of pneumoconiosis under § 718.202(a) or total disability under § 718.204(b)(2), Claimant cannot establish total disability due to pneumoconiosis under § 718.204(c)(2).

F. Conclusion

Because Claimant has not established any elements of entitlement, the claim must be denied.

ORDER

The claim of JOSEPH R. KUFROVICH for benefits under the Act is DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.